INDIANA OCCUPATIONAL THERAPY COMMITTEE
SUPERVISION LETTER

INSTRUCTIONS: Applicants applying for a temporary permit to practice as a occupational therapist or occupational therapy assistant must have this supervision letter completed. The letter must be completed and have original signature by the certified Indiana occupational therapist who will be providing direct supervision. No fax copies are acceptable.

Complete, sign and return to the: Indiana Health Professions Bureau
402 West Washington Street, Room W041
Indianapolis, Indiana 46204

APPLICANT INFORMATION

_____ _____
Name of applicant (last, first, middle, maiden) Social Security number

HOSPITAL/FACILITY INFORMATION

_____
Name of hospital/facility

_____
Address

_____
City, state, ZIP code

TO BE COMPLETED BY SUPERVISOR

I hereby swear or affirm under the penalties of perjury that the applicant whose name appears above will be under my direct supervision while practicing occupational therapy. According to Indiana Code 25-23.5-5-11 (b) and 844 IAC 10-5-13, I understand that I shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed. I also understand that the patient's care shall always be my responsibility.

_____ _____
Printed name of supervisor Telephone number

_____ _____
Signature of supervisor Dated signed (month, date, and year)

_____ _____
Certification number and expiration date Date supervision to begin (month, date, and year)